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FISCAL IMPACT STATEMENT

LS 7142
BILL NUMBER: HB 1280

NOTE PREPARED: Jan 6, 2011
BILL AMENDED:

SUBJECT: Health Disparities in Medicaid.

FIRST AUTHOR: Rep. Crawford
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X **GENERAL**
X **DEDICATED**
X **FEDERAL**

IMPACT: State

Summary of Legislation: This bill has the following provisions.

Managed Care Requirements: This bill defines a managed care organization (MCO) as an MCO providing risk-based managed care, or a contractor that provides the administration or coordination of managed services including a pharmacy benefits manager, a behavioral health services coordinator, or a case management coordinator. The bill requires a risk-based MCO that contracts with the Office of Medicaid Policy and Planning (OMPP) to do the following:
(1) Report to the Select Joint Commission on Medicaid Oversight (JCMO) concerning the MCO's culturally and linguistically appropriate services (CLAS) standards plan and the progress in implementing these standards.
(2) Implement standards concerning CLAS and encourage practices that are more culturally and linguistically accessible.
(3) Develop and administer a community-based health disparities advisory council.

Medicaid Direct Service Provider Requirements: The bill requires Medicaid contractors including pharmacy vendors to implement at least two quality improvement initiatives to reduce health disparities. The initiatives must: (1) include baseline data on clients of the provider, (2) include measurable goals and outcomes, and (3) use a third-party source to evaluate the contractor's initiatives.

Office of Medicaid Policy and Planning Requirements:

Withholding MCO Reimbursement: Beginning January 1, 2012, the bill requires OMPP to withhold a percentage of reimbursement from a contracted risk-based MCO based on a lack of progress in improving

health disparity outcomes.

Procurement Requirements: The bill requires that OMPP requests for proposals (RFPs) must include criteria evaluating the MCO's cultural competency in working with minority populations, and requires preferences to be awarded in the bidding process to an MCO that shows evidence of cultural competency.

The bill requires OMPP to: (1) annually report specified information to the Legislative Council, the Select Joint Commission on Medicaid Oversight, and the Commission on Mental Health; and (2) establish standards and guidelines and ensure continuity of care for Medicaid recipients who transfer from an MCO.

Withholding MCO Reimbursement: Beginning January 1, 2012, the bill requires OMPP to withhold a percentage of reimbursement from a contracted risk-based MCO based on a lack of progress in improving health disparity outcomes.

Board of Pharmacy Requirements: The bill requires the Indiana Board of Pharmacy to report to the JCMO during the 2011 interim concerning the feasibility and cost of requiring pharmacies to print prescription labels in foreign languages and the number of foreign languages the board would recommend.

Effective Date: Upon passage; July 1, 2011.

Explanation of State Expenditures: *Managed Care Requirements:* The provisions of the bill would apply to risk-based MCOs, pharmacy benefits managers, case management coordinators, and behavioral health services coordinators that contract with OMPP for risk-based managed care. This would include managed care services in Medicaid, the Children's Health Insurance Program (CHIP), and the Healthy Indiana Plan (HIP).

Any additional MCO costs required by the bill would occur within the individual contracts. For risk-based managed care, the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care or the MCO's administrative costs. The bill would result in increased costs to the state to the extent that increased risk-based managed care costs, which must be actuarially determined, would be passed through to the state in the negotiated rates for the CY 2012 capitation rate. The application of the bill's requirements to other contractors meeting the MCO definition in the bill would depend on the specific terms of the individual contracts. The fiscal impact would depend on actions taken by all the MCOs to implement the provisions of the bill affecting the individual contractors. Additional costs would be anticipated to be passed through the contracts to the state.

RFP Requirements: The bill would require all future RFPs for all managed care services to include criteria concerning the bidder's cultural competency in working with minority populations for evaluation of proposals and award preference points to bidders that provide evidence of cultural competency. This provision should be achievable within the level of resources available to the agency for administrative functions.

OMPP Reporting Requirements: The bill requires OMPP to include in the required annual report to the Legislative Council additional specified Medicaid information concerning the number of recipients that transfer from one risk-based MCO to another, the reasons for the transfers, and the health outcomes of the recipients six months after the transfers. The additional data elements specified may require additional data collection by either the MCOs or OMPP. The health outcomes information requires the risk-based MCOs to do two health assessments; the first within 15 days of the transfer and the second within 6 months of the

transfer. The level of resources required to do the health assessments and to obtain and report the specified data is not known at this time. Any additional cost associated with the health assessments would be passed through to the state in the negotiated rates for the CY 2012 capitation rate.

Withholding MCO Reimbursement: The bill would require OMPP to withhold a percentage of reimbursement from a risk-based managed care organization that shows a lack of progress in improving health disparity outcomes. This provision would not be enforceable until it is included in a contract amendment or a new contract. OMPP currently includes pay for performance in the MCO contracts. Quality performance measures are determined and target levels are set by OMPP. MCOs that meet or exceed the goal levels are eligible for additional payments.

Medicaid Provider Quality Initiatives: The bill requires any person that receives reimbursement under Medicaid or that contracts with OMPP to provide direct services to implement at least two quality improvement initiatives in obstetrics, asthma, diabetes, immunizations, or the items included in the HEDIS data set. At least one of the initiatives must address race, ethnic, or other geographic disparities. The providers would be required to include baseline data on individuals receiving services from the provider, include measurable goals and outcomes, and use a third-party source to evaluate the provider's initiatives. This requirement appears to apply to all providers regardless of the amount of reimbursement involved or the volume of services provided. Sole practitioners, Area Agencies on Aging, hospitals, nursing facilities, and MCOs would be required to comply. The bill does not provide any enforcement authority or require reporting of the quality improvement initiatives, outcomes, or evaluations. This provision could affect Medicaid eligibles' access to services if providers decide to discontinue accepting Medicaid reimbursement as a result of this provision.

The Medicaid program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 34%. Most Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 66%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Background & Additional Details on MCO Requirements- Additional requirements imposed on MCOs by the bill include the following.

(1) The Medicaid risk-based MCOs are required to report to the JCMO concerning the MCO's culturally and linguistically appropriate services standards plan and the progress in implementing these standards. This reporting requirement alone should not result in additional cost to the MCOs or the state.

(2) OMPP or the enrollment contractor is required to report information concerning race and the primary language of the members enrolled with the MCO to the MCO. States are required to provide this information to the MCOs. OMPP reported in the *Quality Strategy Overview* for 2008, that the Medicaid application process solicits information on the applicant's race and primary language. At that time, however, OMPP did not have the ability to transmit the race data to the risk-based MCOs. OMPP was also investigating the possibility of collecting ethnicity data during the application process. It was further reported that data regarding the primary language spoken is sent to the risk-based MCOs twice monthly. It is not known at this time what progress was made by OMPP on providing the race and language data to the risk-based MCOs. Risk-based MCO contracts contain language requirements compliant with federal regulations. The extent to which OMPP has the ability to transmit race and language data to other providers that meet the definition of MCO in this bill is not known.

(3) The bill requires the risk-based MCOs to establish and administer standards concerning culturally and linguistically appropriate services. The standards are to be included in a written plan to encourage practices that are more culturally and linguistically accessible. The MCOs are required to report annually on the progress of the plan to the Interagency State Council on Black and Minority Health.

(4) The bill requires the risk-based MCOs to establish and administer a community-based health disparities advisory council. The bill allows the MCOs to collectively establish the health disparities advisory council. The bill requires the council(s) to have nine specified members representing certain constituencies and then provides that 75% of the council membership must be certain individuals that are not employed by the MCO. The bill specifies the duties of the health disparity advisory council(s) and also provides that the MCOs are required to pay for the costs of the council(s), including travel expenses of the members. The MCO contracts would probably need to be amended to include this provision. Cost to the state would be passed through the contractual capitated payments the state pays the risk-based MCOs.

(5) The bill also requires the Board of Pharmacy to report to the JCMO concerning the feasibility and cost of requiring pharmacies to print prescription labels in foreign languages. This requirement should have no fiscal impact on the Board of Pharmacy.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

Explanation of Local Expenditures: Local government-owned hospitals and health facilities as well as local school corporations that bill for Medicaid services would be required to comply with the Medicaid quality initiatives.

Explanation of Local Revenues:

State Agencies Affected: FSSA, OMPP, DoA, DMHA; Indiana Professional Licensing Agency, Board of Pharmacy; Indiana State Department of Health.

Local Agencies Affected: Local government-owned hospitals and health facilities; Local school corporations.

Information Sources: U.S. Government Accountability Office, GAO-05-44R Medicaid Managed Care Access and Quality Requirements; *State of Indiana Office of Medicaid Policy and Planning, Quality Strategy, 2007-2008*.

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